



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Seton Medical Center Williamson

Respondent Name

Zenith Insurance Co

MFDR Tracking Number

M4-14-1066-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

December 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Under normal circumstances the utilization review process establishes the medical necessity of a treatment before the service is rendered. As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code §19.2015..."

Amount in Dispute: \$3,956.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Zenith Insurance Company maintains its position that the services were not authorized nor related to the industrial injury and no reimbursement is due."

Response Submitted by: Zenith Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 13 – 14, 2013	Outpatient Hospital Services	\$3,956.64	\$3,956.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – This charge represents services that were not authorized for payment.

Issues

1. Did the respondent appropriately reject the medical bill in dispute?
2. Were the disputed charges subject to prior authorization?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "the services were not authorized nor related to the industrial injury." Applicable 28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the response to MFDR. The division concludes that the carrier raised a new denial reason. For that reason, the carrier's position regarding non-compensability shall not be considered in this review.
2. In its request for medical fee dispute resolution, the requestor states that "As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code §19.2015..." This rule reference is related to Administrative Violations and is not applicable in this instance. However, 28 Texas Administrative Code §134.600 states the following in regards to type of service in dispute, "(p) Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of the section;" However, 28 Texas Administrative Code §134.600(c)(1) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

Review of the medical records submitted with this dispute finds the following;

- a. Patient care record from Burnet Fire and EMS showing transport from Seton Highland Lakes to Seton Williamson County on July 13, 2013.
- b. Facesheet from Seton Medical Center Williamson showing diagnosis to be, "Other postoperative infection."
 - i. Pain level reported to be 10
 - ii. Admitted 2 days after arthroscopy with positive aspiration for gram-positive cocci in the left knee.

28 Texas Administrative Code 133.2(5) defines an emergency as "(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;" Therefore, the Division finds the definition of emergency is met and the carrier is liable for the disputed services. The services in dispute will be reviewed per applicable rules and guidelines.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code J1580 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100, date of service July 14, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service July 14, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 87075 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.01. 125% of this amount is \$16.26
- Procedure code 87070 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.84. 125% of this amount is \$14.80
- Procedure code 87205 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.87. 125% of this amount is \$7.34
- Procedure code 29871 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,111.62. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,266.97. This amount multiplied by the annual wage index for this facility of 0.9615 yields an adjusted labor-related amount of \$1,218.19. The non-labor related portion is 40% of the APC rate or \$844.65. The sum of the labor and non-labor related amounts is \$2,062.84. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.162. This ratio multiplied by the billed charge of \$12,390.00 yields a cost of \$2,007.18. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$2,062.84 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$786.26. The allocated portion of packaged costs is \$786.26. This amount added to the service cost yields a total cost of \$2,793.44. The cost of these services exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$2,062.84. This amount multiplied by 200% yields a MAR of \$4,125.68.
- Procedure code 97001, date of service July 14, 2013, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the

highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2013 is \$71.68. This amount divided by the Medicare conversion factor of 34.023 and multiplied by the Division conversion factor of 55.3 yields a MAR of \$116.51

- Procedure code G0378, date of service July 14, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is \$4,280.59. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$3,956.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,956.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$3,956.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	July , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.